TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-3110-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $71.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed for filling a prescription of Carisoprodol to the claimant. ODG indicates Carisoprodol has an "N" status that requires preauthorization per Rule 134.530. Texas Mutual has no record preauthorization was sought or obtained nor has the requestor provided any evidence of preauthorization approval in its DWC60 packet."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2015	Carisoprodol 350mg	$71.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out requirements for use of the closed formulary for claims not subject to certified networks.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes;

- 197 – Precertification/authorization/notification absent.
- A11 – Preauthorization required for "N" drugs in ODG Appendix A per Rule 134.503 & 134.504

Issues

1. Did the carrier support that denial reason?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 197 – "Precertification/authorization/notification absent."

   Review of the TX COMP claim profile at https://txcomp.tdi.state.tx., shows no active Certified network. Therefore, the applicable rule is 28 Texas Administrative Code §134.530 which states in pertinent part, "(b) Preauthorization for claims subject to the Division's closed formulary. (1) Preauthorization is only required for:

   (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

   (B) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and

   (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a)."

   Review of the submitted medical claim finds;

   a. Appendix A, ODG Workers' Compensation Drug Formulary lists – "Caprisoprodol with a status of "N".
   b. State of Pharmacy Services / DWC066 (no prior authorization present)

   As this is a prescription medication with an "N" status, prior authorization was required but was not obtained. The Carrier's denial is supported.

2. As no documentation was found to support the requirements of Pharmacy Rule 134.530 were met, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 30, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.